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No. 99-1786

IN THE

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE CO.,
Petitioner,

v.

JANETTE KNUDSON
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION OF SELF-INSURANCE INSTITUTE OF AMERICA, INC. (SIIA) FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONER AND BRIEF *AMICUS CURIAE* OF SELF-INSURANCE INSTITUTE OF AMERICA, INC. (SIIA) IN SUPPORT OF PETITIONER

GEORGE J. PANTOS
SELF-INSURANCE INSTITUTE
OF AMERICA, INC.
1250 H Street, N.W.
Suite 901
Washington, DC 20005
(202) 463-8161
Counsel for Amicus Curiae

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20001

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MOTION OF SELF-INSURANCE INSTITUTE OF AMERICA, INC. (SIIA) FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONER

To the Honorable Chief Justice and Associate Justices of the Supreme Court of the United States:

The Self-Insurance Institute of America, Inc. (SIIA) respectfully moves this Court, pursuant to Supreme Court Rule 42 (3), for leave to file the accompanying brief in this case as *amicus curiae* in support of the Petitioners and urging reversal of the decision of the Court of Appeals for the Ninth Circuit. In support of this motion, SIIA shows as follows:

1. This motion is necessitated by the refusal of the Respondent to consent to the filing of a brief by SIIA as *amicus curiae*.

2. SIIA is a non-profit corporation of over 700 members, representing almost 15 million Americans, dedicated to the advancement and protection of the self-insurance industry. SIIA's membership

includes users of self-insurance such as employer plan sponsors, as well as service providers such as third-party administrators, reinsurance companies, and other entities engaged in the self-insurance business. SIIA is the only association in the U.S. which exclusively represents firms, professionals, and organizations which participate in the broad spectrum of self-insurance, including self-insured group health plans. Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public on how the self-insurance system functions, and on the impact of government regulations and interpretations under the Employee Retirement Income Security Act of 1974, ("ERISA") 29 U.S.C. §§ 1001 *et seq.*, concerning self-insured health plans and plan participants. This includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to members. Indeed, SIIA filed a brief as *amicus curiae* and this Court granted SIIA's motion and accepted SIIA's brief as *amicus curiae* in support of the petition for certiorari in this case (Order of January 22, 2001).

3. SIIA has an interest in the ERISA issue presented in this case—whether an employee benefit plan fiduciary may seek to recoup benefit payments advanced to a plan participant where the plan participant receives payments from an individual or insurance carrier due to the negligence of a third party under ERISA Section 502 (a) (3), 29 U.S.C. § 1132 (a) (3)—for three reasons. First, the issue presented is of major concern to the self-insurance industry because the rising cost to employers and plan participants covered under employer sponsored health plans will escalate further if self-insured plans are not able to recoup benefit payments advanced to covered participants in reliance on plan terms which contain a right of recovery. This will result either in reduced health care benefits, or delay in benefit payments pending the outcome of third-party legal action, or higher out-of-pocket costs for covered participants in the form of higher co-payments and deductibles, or both. The Ninth Circuit's decision may even threaten the continued viability of self-insurance as a cost-efficient alternative for providing health benefits to millions of employees. Second, because many SIIA employer members operate on a multi-state basis, they are legitimately concerned that any erosion of ERISA's provisions will not only severely disrupt the operation of their plans but also will lead to plans abandoning attempts to recover money paid to participants under reimbursement clauses in ERISA plans which have been agreed to in advance by plan participants. Third, if participants retain personal injury settlements contrary to plan terms, the risk of medical expense payments for injuries caused by third-parties will needlessly shift to employer-sponsored plans thus creating a "windfall" for employees who receive recoveries from the responsible party.

WHEREFORE, it is respectfully moved and requested that the Self-Insurance Institute of America, Inc. (SIIA) be granted leave to file the accompanying brief as *amicus curiae*.

Respectfully submitted,

GEORGE J. PANTOS
1250 H Street, N.W.
Suite 901
Washington, DC 20005

Counsel for Self-Insurance Institute of America, Inc.

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BRIEF *AMICUS CURIAE* OF SELF-INSURANCE INSTITUTE OF AMERICA, INC. (SIIA) IN SUPPORT OF PETITIONER

The Self-Insurance Institute of America, Inc. (SIIA) hereby submits this brief in Case No. 99-1786 urging reversal of the decision of the United Sates Court of Appeals for the Ninth Circuit entered in this case on May 10, 2000.

INTEREST OF THE *AMICUS CURIAE*

A statement describing SIIA and its interest in this case is set forth in the preceding motion requesting leave to file this brief *amicus curiae*.

SUMMARY OF ARGUMENT

The Ninth Circuit's implicit rationale that suits by fiduciaries pursuant to plan reimbursement provisions to recoup payments made to a beneficiary cannot be characterized as "equitable relief" under ERISA § 502 (a) (3), 29

U.S.C. § 1132 (a) (3) is unsupportable in light of ERISA's explicit language, the purpose of the Act, and contrary opinions of other Circuits. By failing to recognize that the federal court has subject matter jurisdiction over an action by a fiduciary of an employee benefit plan subject to ERISA to enforce the provisions of a plan, the Ninth Circuit adopts an extreme judicial interpretation which prevents a fiduciary from doing what Congress intended it to do within the scope of ERISA to protect plan assets and the financial integrity of the plan in the interest of plan participants.

The Ninth Circuit's interpretation of ERISA § 502 (a) (3) creates an ill-conceived precedent that directly affects thousands of self-funded health plans which provide benefits to millions of participants. Since the passage of ERISA, SIIA members have established and administered self-funded plans in reliance upon a federal statutory framework and federal common law which expressly recognize the substantial importance of the proper enforcement of ERISA plan terms that allow recoupment of significant amounts of money on behalf of plans and participants. SIIA members are deeply concerned that judicial determinations which prevent recovery of health benefit payments will result in a "windfall" to participants who receive such payments and a "dead loss" to self-funded plans and their participants. This will significantly increase overall health plan costs and will have detrimental implications both for covered participants and beneficiaries who will bear the ultimate cost-shifting burden of those costs, and for the continued growth of self-insured health benefit programs as a viable and cost-efficient alternative to traditional insurance.

ARGUMENT

I. A CIVIL ACTION TO ENFORCE THE TERMS OF AN ERISA PLAN WHICH INCLUDES A RIGHT TO REIMBURSEMENT PROVISION IS AN EQUITABLE ACTION WITHIN THE MEANING OF ERISA SECTION 502 (a) (3)

The express statutory language in Section 502 (a)(3) of ERISA, 29 U.S.C. § 1132 (a) (3), authorizes a plan fiduciary to bring a civil action to enjoin any act that violates the terms of a plan and "to obtain *other appropriate equitable relief* . . . to redress such violations or . . . to enforce . . . the terms of the plan." U.S.C. § 1132 (a) (3). ERISA imposes on fiduciaries a duty to preserve plan assets for the benefit of *all* participants and beneficiaries "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with" Parts I and IV of Title I of the Act. 29 U.S.C. § 1104 (a) (1) (D). ERISA health plans usually include a recovery provision that gives the plan the right to recoup amounts paid to a participant by the plan for medical expenses when payment has been received by the participant from a third party tort feasor.[1] This "right of reimbursement "is designed to prevent unjust enrichment (double recovery) by a single participant in order for the plan sponsor to preserve plan assets to satisfy future claims for *all* participants and beneficiaries—a fundamental principle of ERISA.[2] When a benefit payment is conditioned

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[1] Typically, reimbursement provisions are incorporated in the terms of the plan which are also disclosed to participants in Summary Plan Descriptions (SPDs). It is also a common practice to require participants to sign an agreement promising to reimburse the plan before any medical expenses will be paid. Such reimbursement agreements which are part of the SPD become part of the plan documents enforceable under ERISA.

[2] Additionally, plan fiduciaries who seek to enforce the terms of its provisions can initiate a civil action under the general federal question provisions of 28 U.S.C. § 1331(a). This provides that district courts "shall

on the covered participant's reimbursement to the plan out of funds recovered from a third-party, a participant who retains the amount recovered from a third party and does not reimburse the plan is unjustly enriched.

An action to enforce express plan terms that include a right to recovery provision constitutes an action to obtain "appropriate equitable relief" within the meaning of Section 502 (a) (3). The Court recently confirmed that restitution under Section 502 (a) (3) is governed by common-law remedial principles. *See Harris Trust & Savings Bank v. Salomon Smith Barney, Inc.*, 120 S. Ct. 2180, 2189-2190 (2000). Respondent's reliance on *Mertens v. Hewitt Associates* 508 U.S. 2484 (1993) to limit the meaning of "equitable relief" under 29 U.S.C. § 1132 is overly restrictive. The Ninth Circuit's holding that under *Mertens* an action for restitution under Section 502 (a) (3) is limited to recovery of "ill-gotten gains," *i.e.* "money obtained through fraud or wrong doing" ignores the essential elements of a restitution claim which this Court held in *Harris Trust* is governed by common-law remedial principles, not notions of "wrong doing". The right to *restitution* and the right to *reimbursement* fall within the categories of relief recognized as "equitable" by the Court in *Harris Trust*. Thus, proof that funds were obtained by

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have original jurisdiction of all civil actions arising under the Constitution, laws or treaties, of the United States. "Laws" in this provision has been held by the Supreme Court to include claims founded upon federal common law, *Illinois v. City of Milwaukee*, 406 U.S. 91, 100 (1972). Citing *City of Milwaukee* several courts have held that ERISA actions governed by federal common law "arise under" federal law for purposes of § 1331. *Airco Industrial Gases v. Teamsters H&W Fund*, 850 F.2d 1028 (3rd Cir. 1988); *Whitworth Bros. Storage v. Teamsters Central States Pension Fund*, 794 F.2d 221 (6th Cir.), *cert. den.*, 479 U.S. 1007 (1986); *Northeast Dep't ILGWU v. Teamsters Local 229*, 764 F.2d 147 (3rd Cir. 1985). It appears from these decisions that there should be no significant jurisdictional obstacles to a Plan bringing suit under ERISA to enforce the reimbursement provision set forth in plan documents.

ill-gotten means is not a requirement under common law equitable remedy principles, such as restitution.

In the ERISA context, the right to reimbursement has been recognized by several courts of appeal as an appropriate equitable remedy to prevent participants from collecting from both the plan and the tort feasor (wrong-doer) and failing to reimburse the plan. In *Administrative Committee v. Gauf*, 188 F. 3d 767 (7th Cir. 1999) the Seventh Circuit noted that it "consistently has held that a complaint purporting to state a claim for equitable relief under a reimbursement clause in a benefits contract is an equitable claim for purpose of ERISA Section 502 (a) (3).[3]

The Eleventh Circuit in *Blue Cross & Blue Shield of Alabama v. Sanders*, 138 F. 3d 1347 (11th Cir. 1998) concluded that the Ninth Circuit's earlier reliance on *FMC Medical Plan v. Owens*, 122 F. 3d 1258 (9th Cir. 1997) reflects an "unduly narrow reading" of the Court's decision in *Mertens* which stated that "appropriate equitable relief" under 29 U.S.C. § 1132 (a) (3) (B) means *only* relief "*typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Sanders*, 138 F. 3d at 1325. In specifically rejecting this restrictive reading of "appropriate equitable relief," the Eleventh Circuit recognized a suit by a fiduciary to enforce a plan reimbursement term as a suit for specific performance, which it found to be a "traditional form of equitable relief" under ERISA Section 502 (a) (3).[4]

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[3] *See Harris Trust & Savings. Bank v. Provident Life and Accident Ins. Co.*, 57 F. 3d 608, 615 (7th Cir. 1995); *Central States, Southeast & Southwest Areas Health and Welfare Fund v. Neurobehavioral Assocs.* 53 F. 3d 172, 173-174 (7th Cir, 1995).

[4] *See Owens-Illinois v. Lake Shore Land Co., Inc.*, 610 F. 2d 1185, 1189 (3rd Cir. 1979) ("action for specific performance without a claim for damages is purely equitable").

The Eighth Circuit similarly held that federal courts have exclusive jurisdiction over civil actions brought by fiduciaries under Section 1132 (a) (3) for equitable relief to enforce, or redress violations of ERISA plan terms. *Southern Council of Industrial Workers v. Ford*, 83 F. 3d at 969 (8th Cir. 1996).

Moreover, the Ninth Circuit failed to recognize a developing federal common law of unjust enrichment under ERISA. Recent decisions have begun to develop a right of recovery under ERISA federal common law modeled on traditional equitable remedial principles. [5] In *Provident Life & Accident Ins. Co. v. Waller*, the Fourth Circuit held that where the provisions of a Plan provide for repayment of advanced monies, and the result in question is undeniably unjust enrichment, a plan's recovery of payments is consonant with ERISA's purposes.

II. PREVENTING ENFORCEMENT UNDER ERISA OF A RIGHT TO REIMBURSEMENT WILL ADVERSELY AFFECT SELF-FUNDED HEALTH PLANS AND PARTICIPANTS

A. Health Plan Costs Will Increase

ERISA's preemption language provides a significant impetus for companies to self-fund employee health benefits. Congress helped foster the favorable federal legal regulatory environment that has resulted in a phenomenal growth of self-funded plans and employer sponsored health care.[6] This

[5] *Provident Life & Accident Insurance Co. v. Waller*, 906 F. 2d 985 (4th Cir. 1990) *cert. den.*, 498 U.S. 982 (1990) (recognizes a federal common law of unjust enrichment); *See Luby v. Teamster, Health Welfare and Pension Funds*, 944 F. 2d 1176 (3rd Cir. 1991) (recognizes a right of restitution to the plan for mistaken benefit payments following the rationale of *Waller*.

[6] Approximately 55 million out of 152 million participants in employment based plans (36 percent) were in self-funded plans in 1997. *Employment-Based Health Care Benefits and Self-Funded Plans*, Employee Benefit Research Institute (February 2000). The survey also found that 60 percent of firms with 500 or more employees self-fund their health benefits and 29 percent of firms with 100-499 employees are in self-funded plans. EBRI survey at 5. According to a survey by William M. Mercer, Inc., a total of 68% of employers with indemnity health plans self-insured them in 2000. Greenwald, *Health Cost Volatility May Spur Shift in Self-Funding*, Business Insurance, February 19, 2000 at 3.

growth also reflects recognition of self-insurance as a viable alternative for funding health benefits, and as a cost-efficient method of providing expanded benefit coverage during a period of rapidly escalating health costs.[7]

An important factor which has contributed to this growth within the present federal regulatory framework is the flexibility of plan design. Right to reimbursement clauses, a feature commonly found in employer-sponsored self-funded plans, are designed to preserve plan assets which can be used to pay enhanced benefits to covered participants by allowing recovery of paid medical expenses which are the financial responsibility of other parties.[8] Generally, right to reimbursement provisions permit plan recoveries for medical expenses paid by a plan for injuries sustained in automobile accidents, from product defects, in accidents on private or public property or for malpractice by hospitals and doctors, where

[7] According to a survey by the Kaiser Family Foundation, health care costs increased by 8.3 percent between 1999 and 2000. This was the highest increase reported by the study since 1993. *Health Research & Educational Trust "2000 Annual Employer Benefit Survey"*, Business Insurance, December 18, 2000 at 22. According to a survey by William M. Mercer, Inc. health care costs could rise by an average of 11 percent in 2001. That double-digit increase would come on top of the 8 percent increase in 2000, Business Insurance, December 18, 2000 at 22.

[8] Duplicate Medicare payments are also subject to recovery from beneficiaries by the Health Care Financing Administration for injuries already reimbursed by automobile and liability insurance. *See*, generally, CCH Medicare and Medicaid Guide ¶ 4142 (Vol. 1 at p. 1372); HCFA Reg. §§ 411.20 *et seq.*, CCH Medicare and Medicaid Guide ¶ 20,881.32 to .54 (Vol. 4 pp. 8264-8274.).

such expenses are also payable to participants pursuant to legal action or settlement in civil cases. Such reimbursement does not reduce medical expenses which are otherwise paid to participants in the absence of a third party recovery. They simply eliminate duplicative payments and preserve limited benefit dollars which are used to pay expanded health care benefits to all participants.[9]

Preventing enforcement under ERISA of plan terms which include a right to reimbursement or subrogation, however, results in less money in plans to pay medical benefits thus forcing many employers to reduce or eliminate certain benefits. Faced with higher costs, plan sponsors would be encouraged to defer or delay payment of claims for medical expenses related to third party negligence until the accident liability issues have been fully resolved or until after third party litigation has been terminated. Plan sponsors are likely to amend their plans to exclude coverage for medical expenses related to negligent third-party. In other cases, in order to maintain current benefit coverages and levels, higher plan costs will be shifted to plan participants in the form of higher co-payments and larger deductibles. Inevitably, interference with sound cost-containment health plan practices such as reimbursement clauses will threaten the continued viability of self-insurance as an acceptable method of providing health benefits to participants.

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[9] The subrogation program of *amicus*, Central States, Southeast and Southwest Areas Health and Welfare Fund, for example, has achieved recoveries and savings of approximately $62 million since its inception. Brief of *Amicus Curiae* Central States, Southeast and Southwest Areas Health and Welfare Fund on *Petition for Writ of Certiorari* at 2 in *Cement Masons Health and Welfare Trust Fund for Northern California et.al. v. Stone*, 197 F.3d 1003 (9th Cir. 1999) *petition for cert.* filed 68 U.S.L.W. 3566 (Feb. 22, 2000) (No. 99-140). For 2000, Healthcare Recoveries, Inc., a nationwide provider of healthcare subrogation services, reported subrogation recoveries averaging approximately $4.8 million for each 1 million persons covered by its clients. *SEC 10K Form filed March 27, 2001.*

B. The Administrative Burdens of Operating Self-Funded Plans Will Increase

Another negative effect of disallowing enforcement of plan terms which include a reimbursement provision is the increased complexity which will result from administering self-funded plans on a state-by-state basis. Since adoption of ERISA, such plans have been established and operated on a nationally uniform basis and free from state regulation. If reimbursement clauses in ERISA plans are invalidated, employers may be forced to seek relief in various state courts. Monitoring and compliance with varying and often inconsistent state requirements and precedents will create significant new administrative burdens.[10] Instead of promoting order and greater uniformity, greater fragmentation and confusion will result.

For example, plan amendments which defer payment of accident related claims until after liability issues have been fully and finally resolved would result in disparate treatment of similarly situated plan beneficiaries. Since each state has its own statute of limitations applicable to a participant for bringing a claim, plan beneficiaries covered under a single plan which offers coverage in multiple states would be treated dissimilarly. To the detriment of plan beneficiaries, such plan terms would be certain to cause delay and disparate treatment in the administration of health plans benefits.

C. The Continued Viability of Self-Insurance As An Alternative Method of Providing Health Benefits Is Threatened

It is a long-standing practice that certain risks, including the medical expenses of employees, can be financed by

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[10] For example, in Pennsylvania subrogation or reimbursement is statutorily prohibited in relation to motor vehicle accidents, but in Indiana subrogation or reimbursement is governed by a statute that prorates recoveries in accordance with Indiana law.

employers from their own current revenues. When such benefits are not insured, directly or indirectly, no insurance company is responsible for providing them. Indeed, even prior to ERISA, state courts understood that an employer who self-funds health benefits is not in the "insurance business." *Farmer v. Monsanto Co.*, 517 S.W.2d 129 (Mo. 1974).

Unlike conventional insurance where the risk of loss is *transferred* to an insurance carrier upon payment of a premium, self-insurance is generally understood to mean the *self assumption* (or retention) of one's own risk of a particular loss. As an integral part of a firm's risk management program, self-insurance can include the assumption of all or part of a firm's risk of loss for health benefits, property and casualty exposures and workers' compensation liabilities. Thus, employers seeking a cost-effective alternative to conventional insurance increasingly have adopted self-insured programs in managing various elements of risk related to the business enterprise.

Considerations which have stimulated the utilization of self-insurance for funding health benefits include direct control over claims settlements, greater flexibility to design and administer health plans to meet specific employee needs, cash flow advantages and freedom from state insurance regulation. For example, firms which pay for health benefits from general assets gain the financial advantage of the time-value of their capital assets. Since medical claims are paid as submitted, firm assets can be retained as working capital and invested. Thus, interest can be earned as funds that otherwise would be paid in the form of premiums for conventional insurance (which includes reserves) are retained by the employer. These unique characteristics and the favorable legal regulatory environment fostered by ERISA have contributed significantly to the dramatic expansion of self-insured health plans.

CONCLUSION

For the foregoing reasons, we respectfully request that the Court reverse the Ninth Circuit decision in this case.

Respectfully submitted,

GEORGE J. PANTOS
SELF-INSURANCE INSTITUTE
OF AMERICA, INC.
1250 H Street, N.W.
Suite 901
Washington, DC 20005
(202) 463-8161

Counsel for Amicus Curiae